Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHRONIC PAIN RECOVERY CENTER
25810 OAK RIDGE DRIVE
THE WOODLANDS TX 77380

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-10-1327-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier processed the medical bills. However, the payments it issued were significantly below fee schedule….Requestor notes that the carrier's reduction is based upon contractual agreement. However, the Requestor is not currently, nor has it in the past become a party to such an agreement. …The Requestor asks that Medical Fee Dispute Resolution issue a Findings and Decision that the Requestor is entitled to reimbursement for the services discussed herein, as well as all fees, interest and any other relief to which the Requestor may be justly entitled…"

Amount in Dispute: $1,287.50**

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier issued pymt for date of service 7-7-09-8-11-09, per the fee guidelines. See EOR-checks."

Response Submitted by: ESIS; PO Box 31108; Tampa FL 33631

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2009	97799-CP-CA (chronic pain management program)	$ 87.50	$ 87.50
July 14 and 15, 2009		$200.00	$200.00
July 16, 2009		$1,000.00	$1,000.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. **The requestor was contacted on December 7, 2011 to obtain a current status of this medical fee dispute. The requestor stated that all dates of service have been paid in full except July 13, 14, 15, and 16, 2009. The requestor submitted an updated Table of Disputed Services for review.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
3. Texas Labor Code §413.011(d-1) sets out the requirement for carriers to provide copies of contracts.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
5. The remaining services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150: payer deems the information submitted does not support this level of service
   - 850-204: medical documentation provided does not support the service (or level of service) billed
   - 900-030: this charge was reviewed through the clinical validation program
   - 45: charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 100: any network reduction is in accordance with the network referenced above
   - 113-001: network import repricing – contracted provider
   - W1: workers compensation state fee schedule adjustment
   - 663: reimbursement has been calculated according to state fee schedule guidelines
   - 850-107: initial allowance recommended in accordance with the state fee schedule guidelines - $1000.00
   - 905-005: the documentation attached supports treatment to the workers compensation injury

Issues

1. Did the requestor have a contracted/legislated fee arrangement?
2. Does the submitted documentation support the services billed?
3. Is the requestor entitled to reimbursement?

Findings

1. Texas Labor Code §413.011 states that the Division may request copies of each contract under which fees are being paid. The Labor Code goes on to state that the insurance carrier may be required to pay fees in accordance with the Division's fee guidelines if the contract is not provided in a timely manner to the Division. On August 4, 2010, the respondent was asked for a copy of the contract between the informal/voluntary network and the requestor. The Division also requested documentation to support that the requestor was notified in accordance with 28 Texas Administrative Code §133.4. The respondent failed to provide a copy of the requested documentation. For that reason, the disputed health care will be reviewed according to 28 Texas Administrative Code §134.204.
2. Disputed date of service July 16, 2009 was denied with reason code 850-204: medical documentation provided does not support the service (or level of service) billed; and reason code 850-107: initial allowance recommended in accordance with the state fee schedule guidelines - $1000.00. According to the Table of Disputed Services, no payment was received. A review of the documentation submitted for this disputed date of service supports services rendered as billed. Reimbursement is recommended.
3. 28 Texas Administrative Code §134.204(h)(5) states in part that reimbursement for a CARF-accredited pain management program (97799-CP-CA) is reimbursed at $125.00 per hour. Reimbursement is calculated as follows for the disputed dates of service:
   - July 13, 2009: $125.00/hr x 7 hrs x 1 DOS = $ 875.00 minus carrier payment of $787.50 = $ 87.50
   - July 14, 2009: $125.00/hr x 8 hrs x 1 DOS = $1,000.00 minus carrier payment of $900.00 = $ 100.00
   - July 15, 2009: $125.00/hr x 8 hrs x 1 DOS = $1,000.00 minus carrier payment of $900.00 = $ 100.00
   - July 16, 2010: $125.00/hr x 8 hrs x 1 DOS = $1,000.00 minus carrier payment of $ 0.00 = $1000.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,287.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,287.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 28, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.